IDAHO STATE BOARD OF MEDICINE

THE REPORT

VOLUME 2008 ISSUE 4 WINTER 2008

Maintenance of Competency

By Bruce Miewald, MD, Committee on Professional Discipline

Over the last several years, driven in part by increased awareness of public safety, there's been a general drive for physicians and others in the healthcare field to demonstrate that they can provide quality care, maintain, and even improve their skills. One of the earliest manifestations of this trend was the development of Continuing Medical Education (CME), which first started in the late 1940s. Currently about 90% of the various medical and osteopathic licensing boards mandate some form of CME, ranging from 12 to 50 hours a year. There have been concerns about the CME system for several years, including the fact that much of it is based on the honor system, for example that a physician truly attended the all day educational course taking place in some exotic location. Also, the current CME system has tended to be rather passive in it's learning style, and does not necessarily demonstrate mastery of clinical skills.

Competency for physicians is obviously hard to define, but many feel that includes the elements below:

- Finding and managing information
- Resolving ambiguous problems
- Emotional intelligence
- Responding to novel situations with flexibility
- Time management
- Teamwork
- Professionalism

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One of the many areas where these changes will be impacting physicians will be a significant change in the system of CME. It will be evolving to be clinically relevant and more importantly, improve the quality of patient care. Rather than attending lectures or reading articles and taking a multiple choice test, there will be "Point Of Care CME", where a physician expands his or her knowledge about a particular area based on an active patient being treated at that time. "Performance Improvement CME" would involve such activities as chart audits and comparison to national benchmarks. Physicians may eventually have to demonstrate their competency in some type of "real life" situation. The type of ongoing testing that airline pilots are required to undergo is often brought up as an example of what physicians may experience.

“Maintenance Of Competency" and "Maintenance of Licensure" are rapidly evolving areas at this point. The days of simply getting a license to practice medicine and then being able to retain it as long as you did not engage in some type of egregious behavior are over. These changes will have a large impact on physicians and their patients. I would encourage the physicians of Idaho to take a proactive approach in this area. We're particularly fortunate, since the Executive Director of the Idaho Board of Medicine, Ms. Nancy Kerr, has been very involved on a national level regarding these issues. The Federation Of State Medical Boards (FSMB) web page has a section dedicated to Maintenance Of Licensure. A partial list of other organizations actively involved in this area include the AMA, the AOA, the Joint Commission, the Accreditation Council for Continuing Medical Education, and the American Academy of Family Physicians.

The Board expressed their appreciation and bid a fond farewell to:

Stephen Marano, MD immediate past Chairman of the Idaho Board of Medicine

Michael Melendez, MD member of the Board of Medicine

The Board Welcomes New Members

Richard White, RT, and Karen Massey, RT, to the Respiratory Therapy Licensure Board

Paula Phelps, PA, to the Physician Assistant Advisory Committee

BOARD ACTIONS

BOARD ACTIONS

PLEASE NOTE

Some physicians have similar names, please verify information by license number on our web site at: www.bom.state.id.us

Explanation of terms:

- Stipulation: an agreement, admission, or concession.
- Stipulation and Order: an agreement between the Board and the practitioner regarding authorization to practice or placing terms or conditions on the authorization to practice.
- Suspension: temporary withdrawal of authorization to practice.
- Reprimand: a formal admonishment of conduct or practice.
- Revocation: cancellation of the authorization to practice.

Thomas J. Andrews, MD

M-7931 California

Allegation: Discipline in California

Board Action: Reciprocal Discipline

Tamara M. Simon, MD

M-8909 Eagle, ID

Allegation: Standard of care, prescribing issues

Board Action: Stipulation and Order

Frank F. Luo, MD

M-10206 California

Board Action: Order imposing fine

Notice of Satisfaction of Order

Christopher R Sundquist PA

PA-303 Post Falls, ID

Allegation: Failure to meet the standard of care, narcotic prescriptions

Board Action: Hearing scheduled March 17, 2009

Raymond Hooft, MD

M-5477 Meridian , ID

Board Action: Motion for Enforcement

Hearing scheduled for March 25, 2009.

Cynthia Satterfield, AT

AT-123 Boise, ID

Allegation: Unprofessional conduct

Board Action: Hearing , Date to be announced

Sara Fagan, PA

PA-760 Idaho Falls, ID

Board Action: Order imposing fine, failure to comply with Patient Freedom of Information Act

Paul Anderson, MD

M-7638 Colorado

Allegation: Discipline in Nebraska

Board Action: Reciprocal Discipline / Surrender of license.

Idaho Medical Board Implements Online Uniform Application for Licensure

On Dec. 3, the Idaho State Board of Medicine became the first state medical board to implement the Uniform Application for Physician State Licensure (UA) into its online licensing processes. The UA, formerly known as the Common License Application Form or CLAF, is part of the FSMB's license portability grant project.

The UA is a standard licensure application form that can serve as the core of a state's license application without replacing unique state-level requirements. The form facilitates online completion of an initial licensure application and can be made available to all state medical boards. By utilizing the UA, physicians can save the application for later use in another state. For physicians who use FCVS, approximately 70 percent of the form can be auto-populated with data.

Currently, 14 medical boards are participating in the license portability project, which is supported by a grant from the U.S. Health Resources and Services Administration. The FSMB develops the UA at no cost to participating boards. For more information, please contact Tim Miller, J.D., at tmiller@fsmb.org or (817) 868-4052. (Reprinted from 12/12/08 Board Net News Federation of State Medical Boards)

More on NPI

A health care provider's National Provider Identifier (NPI) once assigned, lasts for life. It cannot be changed and has no expiration date. The number is used to identify the provider with all health plans across the country. If there are changes in practice location, telephone number or specialization the information needs to be updated but the number remains the same.

If you are no longer providing health care your number needs to be de-activated, your NPI number will never be assigned to another health care provider. De-activating your NPI prevents fraudulent use of your number. If you decide to return to active practice you can re-activate your NPI number.

For questions or assistance please call the NPI at 1-800-465-3203.

A Special Thanks

The Board wishes to extend its appreciation to the following physicians and lay panelists who contributed their time and talents serving the Idaho Board of Medicine as pre-litigation panelists, consultants, or representatives of the Board. Without their time and expertise the Board would not have been able to fulfill its mission of public protection, a special thanks to:

John Migliori, MD
Jeralyn Jones, MD
Charles Novak , MD
Scott Hoopes, MD
Michael Brown, PSG
Mark Rasmus, MD
Daniel Ririe, MD
Grant Belnap, MD
Margaret Wagner, MD
Brett Penney, MD
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Kathie Lautenslager
Karen Leitner
Joyce Magee
John McCabe
Catherine McIntosh
Barb Ross
Joseph Anderson, DO
Joel Carlson, DO
Matthew McLaughlin, DO
Carrie Merrill, DO

Kathy Stanger
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David Spencer, MD
Sherry Stoutin, MD
James Swartley, MD
Terrance Tisdale, MD
Marlin Trainer, DO
Jim Valentine, MD
Robert Walker, MD

Timothy Walker, MD
Troy Watkins, MD
Mark Weight, MD
Mark Weinrobe, MD
John Wick, MD
Shauna Williams, MD
Mark Wineinger, MD
Rick Yavruian, DO
Renee Bobrowski, MD

Medical Care for Deaf People

By: Steven Snow, Executive Director- Council for the Deaf and Hard of Hearing

Imagine you are in another country and fall ill. Imagine you are rushed to a hospital and the doctors are trying to communicate with you about your medical condition in a foreign language that you barely understand. You would want to have a good interpreter who could translate the information into your native language right? In this country, for many deaf people, paying a visit to a doctor office or a hospital is like visiting a location where people speak in a different language.

Idaho is no different. There are approximately 150,000 deaf and hard of hearing citizens living this state. Out of 150,000, more than 15,000 are deaf and most of them depend on sign language to communicate. The deaf and hard of hearing individuals are equally entitled to receive high quality healthcare services. Recently, Idaho Council for the Deaf and Hard of Hearing (CDHH) has documented over a dozen cases of deaf individuals avoiding receiving necessary healthcare due to inflexibility of the doctor office in meeting their communication needs. Most of them gave up after several years of frustrations and struggles of being able to fully participate in their patient-doctor relationship.

A survey found that one in six deaf people avoid going to their doctors because of communication problems and more than one in five (23%) said they lad left a doctor's appointment unsure what was wrong with them. One in six of the deaf and hard of hearing also said they had trouble in arranging a doctor's appointment due to the office's resistance or lack of awareness in hiring an interpreter. Almost half (46%) say they have given up trying to explain how to make communication easier.

I want to point out the excruciating fact that the population at large is more aware of the "visible" disabilities such as blind, wheelchair-bound, etc while the need for communication with the deaf population appears to be less obvious to them. The necessity for sign language interpreters in everyday situations is still largely inadequate and at times, blatantly ignored. The dire need for interpreters in the medical setting is paramount to the adequate delivery of medical care. Correct diagnoses are based on accurate patient histories as well as physical examinations, not infrequently, can save precious time and expensive procedures.

The Americans with Disabilities Act, passed into law nearly 20 years ago, requires hospitals and other public accommodations such as doctor's office, to provide effective communication for deaf and hard of hearing patients. Particularly in serious medical situations, the most effective way to ensure effective communication is by providing sign language interpreters. For most deaf people in North America, American Sign Language (ASL) is their first language and English is their second language. Therefore writing notes back and forth in English is often not a good way for medical providers to communicate clearly and effectively with their deaf patients.

Having full communication through the use of qualified sign language interpreters helps deaf people ensure that they receive timely and accurate medical attention. When a professional interpreter is present, doctors are able to give the correct diagnosis without the misunderstandings and mistakes that happen when effective communication is not provided for them. The best practice of determining whether effective communication exists rests in the view of the patient, not the doctor. Always check with the deaf patients to see if she/he is satisfied with the flow of communication.

Below are a couple of basic tips on how to work with your deaf or hard of hearing patients (with or without interpreters):

- To get their attention, you can either wave your hand, tap their shoulders gently.
- Do not SHOUT. In most cases, this simply doesn't work.
- Ask the deaf person how he or she prefers to communicate, whether it be lip-reading, writing or signing. And try to have patience as it will in almost all cases take longer to have a conversation.
- Even though some people can lip-read very well, lip-reading is still imperfect. Some people at most can understand only 35% of what is being said, and the rest of it is pure guesswork. Try not to have big conversation shifts. Wherever possible, minimize the amount of background noise. Make sure your face is in line of view. If the person shows sign of being confused or getting lost, ask if they understood what you said, and repeat your statements if necessary. Even if the person seems to be following perfectly well, ask them anyway.
- Modulate your voice and speech patterns. If you normally speak very softly, try to consciously speak louder. If you usually speak rapidly, try to slow down.
- Speak directly to the deaf patient, not the interpreter, when using an interpreter to communicate with a deaf patient. The interpreter is not part of the conversation and is not permitted to voice personal opinions or enter into the conversation. Face the deaf person and speak to them in a normal manner.
- Remember that the interpreter is a few words behind the patient. Give the interpreter time to finish so that the deaf person can ask questions or join in the discussion.
- Speak clearly and in a normal tone when using an interpreter. Do not rush through a speech. The interpreter or the deaf patient may ask the doctor to slow down or repeat a word or sentence for clarification.
- Idaho Council for the Deaf and Hard of Hearing (CDHH) is an independent state interagency. By statute, the Council is responsible to increase awareness, advocate for equal access, provide information and referral, monitor consumer protection, recommend public policies and programs, conduct research, and submit reports to the Governor and policymakers. One of our primary goals is to promote and heighten effective communication within the healthcare for the deaf and hard of hearing population. CDHH strongly believes that the result of this would bring forth much-improved quality of life for them. If any doctor's office or the doctors themselves seek trainings or more information on this issue, please contact me at snows2@dhw.idaho.gov.

Calendar of Board of Medicine Meetings for 2009

June 12, 2009
September 11, 2009
December 4, 2009 **

** Meeting scheduled for Board Offices

DEPLOYED?

IF YOU ARE DEPLOYED PLEASE PROVIDE A COPY OF YOUR MILITARY ORDERS FOR DEPLOYMENT AND A COPY OF THE ORDERS RETURNING TO THE U.S. OR RELIEVING YOU FROM ACTIVE DUTY WHEN YOU RETURN. UPON RECEIPT OF THE ORDERS THE BOARD WILL MAINTAIN YOUR LICENSE IN ACTIVE, CURRENT STATUS WHILE DEPLOYED .

IDAHO STATE BOARD OF MEDICINE

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David McClusky, II, MD, Chairman

Trudy Jackson, Public Member

Leo Harf, MD, Member

Laura McGeorge, MD, Member

Michael Melendez, MD, Member

Joyce McRoberts, Public Member

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Ralph Sutherlin, DO, Member

William Cone, MD, Member

COMMITTEE ON PROFESSIONAL DISCIPLINE

A.C. Jones, III, MD, Chairman

Julia Bouchard, MD, Member

Mike Johnson, Public Member

Bruce Miewald, MD, Member

Wendell Wells, MD, Member

Allied Health Board Meetings

Meetings are held in the Board office unless otherwise noted.

The Board of Athletic Trainers meeting April 6, 2009 at 9:30 am

The Dietetic Licensure Board meeting is scheduled for March 10, 2009 at 11:00 a.m.

The Occupational Therapy Licensure Board meeting is scheduled for March 20, 2009 at 9:30 a.m.

The Respiratory Therapy Licensure Board meeting is scheduled for October 15, 2009 at 9:30 a.m.

The Physician Assistant Advisory Committee meeting is scheduled for June 26, 2009 at 9:00 A.M.

Please note if you are submitting a response to a Board inquiry or a completed application, the completed material must be received in the Board office at least 20 days before the scheduled meeting date. Materials not received in that time frame will be added to the next regularly scheduled meeting agenda.

BOARD STAFF

Nancy Kerr, Executive Director

Mary Leonard, Associate Director

Cathleen Morgan, Board Attorney

Beverly Kendrick, Quality Assurance Specialist

Cynthia Michalik, Quality Assurance Specialist

Janet Whelan, Quality Assurance Specialist

Gloria Pedersen, Prelitigation Manager

Darlene Parrott, Compliance Monitor

Terri Solt, Physician Licensing Manager

Jodi Adcock, Allied Health Licensing Manager

Mary McCulley, Finance

Jennifer Winn, PA Licensing Manager

Stephen Tyrer, Investigative Assistant

Robie Harano, Receptionist—Prelitigation

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FAIR AND IMPARTIAL APPLICATION AND ENFORCEMENT OF THE PRACTICE ACTS

CHANGE OF ADDRESS EACH YEAR OF NUMBER OF LICENSE RENEWAL APPLICATIONS GO ASTRAY BECAUSE THE ADDRESS ON FILE WITH THE BOARD IS INCORRECT. AS A RESULT, LICENSES PEOPLE WISH TO MAINTAIN ARE CANCELLED AND HAVE TO BE REINSTATED. PLEASE COMPLETE AND RETURN THIS FORM IF YOUR ADDRESS CHANGES.

ID License No._____

Name_____

(LAST) (FIRST) (MIDDLE INITIAL)

Former Address: _____

(STREET)

_____

(CITY) (STATE) (ZIP)

New Address:

_____

(STREET)

_____

(CITY) (STATE) (ZIP)

Phone (_____)_____Date change becomes effective: _____